Dental Coaching Services
Inventive Dental Solutions
Steve L. Sperry
stevelsperry@gmail.com
c (214)505-6586

GROWTH ASSESSMENT *DATE:* _____

Name (include degree) _____

Corporate Name (if applicable) _____

Office Address _____

_____ _____ _____
(City) (State) (Zip code)

Main Phone # _____ Back Line # _____ Fax Line # _____

Home Address _____

_____ _____ _____
(City) (State) (Zip code)

Home Phone # _____ Cell # _____ E-Mail: _____

Type of Dentist: ☐ General ☐ Specialist (Specialty) _____

☐ Sole Proprietorship ☐ Partnership; if yes what %? _____ ☐ Corporation ☐ Shared Space ☐ Other _____

FACILITY:
* Location: ☐ High Rise ☐ Strip Center ☐ Stand Alone ☐ Other _____
* ☐ Lease ☐ Own Situation * # of Treatment Rooms? Total _____ Doctor _____ Hygiene _____

TECHNOLOGY:
* Dental Software: ☐ No ☐ Yes; Type _____ How long have you used this software? _____
* Work Stations in Front Office? ☐ No ☐ Yes; how many? _____ Work Stations in ops? ☐ No ☐ Yes; how many? _____

RECALL:
* # of hygiene days/wk: _____ Days/mo: _____ Total # of patients seen in last 12 mos. _____
* 1st available appointment on hygiene schedule? _____
* Pre-appointing 6 mos. in advance? ☐ No ☐ Yes % Pre-appointed_____

SCHEDULING:
* Appointment scheduling is: ☐ Manual ☐ Computerized ☐ 10 minutes ☐ 15 minutes increments
* 1st available appointment on doctor's schedule? _____ weeks.

PRACTICE NUMBERS:
* Production Average per Month (last 6 mos.)_____
* Collections Average per Month (last 6 mos.)_____
* Total A/R=$_____ Over 90 days A/R? $ _____
* New Patients per Month (average for last 6 mos.) _____

INSURANCE/PLANS:
* PPO's: ☐ No ☐ Yes; List _____; %_____
* DMO's ☐ No ☐ Yes, List _____; % _____
* Medicaid ☐ No ☐ Yes; List _____; % _____

TEAM MEMBERS:

Name	Position	Years Employed in Your Practice
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		
•		

* Is your Team motivated and enthusiastic? ☐ No ☐ Yes
  Concerns: _____

  _____

* Is there an associate in the practice? ☐ No ☐ Yes; how long? _____
* Associate will be: ☐ Employee ☐ Partner ☐ Other: _____

MOTIVATION:

* Bonus/Profit Pay System? ☐ No ☐ Yes; explain _____

_____

_____

* Trips: _____
* CE: _____
* Other incentives: _____

CASE ACCEPTANCE:

* Selling is done mainly by: ☐ Doctor ☐ Team ☐ Team Member _____
* Are intraoral cameras used in case acceptance? ☐ No ☐ Yes; Frequency: _____
* Are digital photographs used in case acceptance? ☐ No ☐ Yes; Frequency: _____

PLEASE LIST ANY PREVIOUS CONSULTANTS/COACHES YOU HAVE WORKED WITH:

Name	Year
1.	
2.	
3.	
4.	
5.	

PLEASE INCLUDE ANY ADDITIONAL INFORMATION THAT IS SPECIAL OR UNUSUAL TO YOUR PRACTICE THAT IS IMPORTANT FOR ME TO KNOW: _____

CURRENT MARKETING

NEW PATIENT PACKET: Y N CARE CALLS: Y N ASK FOR REFERRALS: Y N
NEWSLETTER: Y N NEWSPAPER: Y N RADIO/TELEVISION: Y N
YELLOW PAGE AD: Y N DIRECT MAIL: Y N COUPONS: Y N
DENTAL REFERRAL SERVICE: Y N WEBSITE: Y N _____
SIGNAGE: NONE GOOD BAD ARE NEW PATIENTS TRACKED: Y N
ARE THANK YOU CARDS OR GIFTS SENT TO REFERRING PATIENTS: Y N

HOW MANY SOCIAL MEDIA SITES ARE YOU ON AS A BUISNESS? _____

PLEASE LIST THEM_____

_____

IF YOU HAVE A FACEBOOK FOR THE PRACTICE HOW OFTEN ARE YOU POSTING? _____

HOW MANY LIKES DO YOU HAVE _____PLEASE ATTACH YOUR ANALYTICS REPORT.
IF YOU ARE ON LINKEDIN AS A PRACTICE, HOW MANY LINKS DO YOU HAVE?_____

IF YOU HAVE A TWITTER ACCOUNT, HOW MANY FOLLOWERS DO YOU HAVE? _____

IF YOU HAVE A GOOGLE+ ACCOUNT, HOW MANY PEOPLE ARE IN YOUR CIRCLES? _____

IF YOU HAVE A YOUTUBE ACCOUNT, HOW MANY VIDEOS ARE POSTED? _____

HOW MANY ONLINE REVIEWS DO YOU HAVE FOR THE OFFICE?_____PLEASE LIST THE

SITES WHERE THEY CAN BE FOUND._____

HAVE YOU DONE ANY DIRECT TO THE PUBLIC PATIENT EVENTS? IF YES PLEASE LIST

HAVE YOU DONE ANY COMMUNITY EVENTS? IF YES PLEASE LIST: _____
_____

DO YOU HAVE A DENTAL APP? IF SO WHICH ONE?_____

DO YOU DO ANY EVENTS OR PROGRAMS FOR THE LOCAL SCHOOLS? IF SO DESCRIBE:
_____

DO YOU HAVE A CULTURE/ENVIROMENT IN YOUR OFFICE THAT IS UNIQUE OR SPECIAL, IF SO DESCRIBE? _____

OTHER MARKETING EFFORTS_____
_____